DATE: **DRAFT**

CRITERIA FOR PRIOR AUTHORIZATION

Appropriate NDC Code
(Item or Procedure Here)

Incretin mimetic agents
(Item or Procedure Here)

PROVIDER GROUP: Pharmacy

MANUAL GUIDELINES: The following drug(s) requires prior authorization:
Exenatide (Byetta®)

CRITERIA: (must meet all of the following)

1. Patient must have a diagnosis of Type 2 diabetes.

2. Documented inadequate glycemic control (HbA1c $\geq$ 7%) with combination therapy of:
   a. Maximum tolerated doses of metformin, unless contraindicated, and
   b. Maximum tolerated doses of sulfonylurea, unless contraindicated.

3. Concomitant therapy with metformin and/or sulfonylurea unless contraindicated.

4. Patient must be monitoring blood glucose levels 3 or more times per day.

Prior Authorizations will be approved for 1 year. Renewals will be approved based on a documented improvement to glycemic control as evidenced by HbA1c lowering from pretreatment levels and adherence to Exenatide and adjunct diabetic medication therapies.

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Drug Utilization Review Committee Director

Date_____

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Pharmacy Program Manager,
Division of Health Policy and Finance

Date_____